Publications and Information Resources

publications catalog

U.S. Department of Health and Human Services
Health Care Financing Administration
Office of Research and Demonstrations

The Health Care Financing Administration (HCFA) was established to combine health financing and quality assurance programs in a single agency. The Agency is responsible for the Medicare program, Federal participation in the Medicaid program, and other health care quality programs.

The Agency provides a series of reports that provide information on a range of topics in the health care financing field, including results and findings from research and demonstration projects and statistics on the Medicare and Medicaid programs. This *Catalog* provides synopses and ordering information on available publications.

Publications Catalog

U.S. Department of Health and Human Services
Health Care Financing Administration
Office of Research and Demonstrations
Publications and Information Resources Branch
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Contents

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Publications must be ordered by title and stock number directly from GPO using the enclosed order form. Send check or money order for the price listed and make payable to: New Orders, Superintendent of Documents, P.O. Box 371954, Pittsburgh, Pennsylvania 15250-7954.

Health Care Financing Status Report, Fiscal Year 1991 Edition

This *Status Report* provides basic information in a brief format on the more than 300 intramural and extramural projects conducted by the Office of Research and Demonstrations that relate to the Medicare and Medicaid programs. These projects seek alternate ways to finance, organize, and deliver health services, as well as assess the impact of Federal programs on health care costs, providers, and beneficiaries. A synopsis of each project is provided which includes the name and address of the awardee, contractor, or grantee organization, the Federal project officer having primary responsibility for the project, a brief description, and current status.

Stock No.: 017-060-00533-5
Price: $7.50 domestic; $8.25 foreign

Medicare and Medicaid Data Book, 1990

This *Program Statistics* report presents a broad overview of the Medicare and Medicaid programs and is the only publication that provides descriptive and comparative data on the two. Data and analyses are presented for enrollees and recipients by demographic characteristics and basis of eligibility on use of and expenditures for selected services. Administration and financing of the programs discussed. Current information on Medicare carriers and intermediaries and Medicaid agencies and fiscal agents is included.

Stock No.: 017-060-00445-2
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Medicare and Medicaid Data Book, 1986

Stock No.: 017-060-00201-8
Price: $8.00 domestic; $10.00 foreign

National Listing of Providers Furnishing Kidney Dialysis and Transplant Services, January 1992

This publication provides beneficiaries and health care professionals with a list of Medicare approved providers who furnish kidney dialysis and transplant services plus aggregated statistics on those providers. This publication is necessary to help recipients obtain the benefits to which they are entitled under the Medicare end stage renal disease (ESRD) program in addition to providing historical statistics on the number of participating providers.

Stock No.: 017-060-00477-1
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Complimentary Publications Available from the Health Care Financing Administration

How to Order

A **limited number of copies** of the following publications are available from: Health Care Financing Administration, Office of Research and Demonstrations, Room 2230 Oak Meadows Building, 6325 Security Boulevard, Baltimore, Maryland 21207, (410) 966-6584. Requests to be placed on our mailing list to

receive notification of future publications as they become available should be sent to the same address.

Consumer Choice and Cost Containment: SAFECO's United Healthcare Plan

This *Grants and Contracts Report* presents an evaluation of the United Healthcare (UHC) experience. It compares UHC with two other health care plans—Blue Cross of Washington and Alaska and Group Health Cooperative of Puget Sound. UHC was successful in recruiting and retaining primary care physicians and in attracting consumers. As a result of the demonstration, a preferred provider network was established. The network is being marketed to employers who are self-funding their medical plans and are interested in lowering costs by offering their employees more comprehensive benefits from a limited number of physicians. Although it is a fee-for-service reimbursement system for physicians, the network uses concurrent utilization review of all hospitalizations, a fee schedule for specialists, and a preselected group of physicians as a new generation attempt at cost containment.

Hospital Data by Geographic Area for Aged Medicare Beneficiaries: Selected Diagnostic Groups, 1986: Volume 1, and Selected Procedures, 1986: Volume 2

This two-volume compilation of data was part of the efforts by the Health Care Financing Administration to provide information on the use of inpatient hospital services and the outcomes of treatment. The information was assembled to display how the rates of inpatient hospital services and the outcomes of care received by Medicare beneficiaries vary by demographic characteristics and across different geographic areas. Volume 1 contains rates of hospitalization, 30-day post-admission mortality, and population mortality for 26 diagnostic groupings. Volume 2 contains rates of hospitalization and 30-day post-admission mortality for 14 procedures. The data reflects only the experience of the 96.7 percent of Medicare beneficiaries who were not enrolled in health maintenance organizations (HMOs) because complete information is not available for HMO enrollees.

Rehospitalization by Geographic Area for Aged Medicare Beneficiaries: Selected Procedures, 1986-87: Volume 3

This report presents information on the outcomes for the aged population of eight important and frequently performed surgical procedures. The focus is on hospital readmissions after surgery because information on this subject is a potentially useful tool in assessing the outcomes of hospital care. Outcomes of hospital care following these procedures are examined with emphasis on demographic and geographic comparisons.

Impact of the Changes in the End Stage Renal Disease Composite Rate

This *Report to Congress* is mandated by section 9335(b) of Public Law 99-509. It is an analysis of the impact that the reduction in the end stage renal disease reimbursement rate has had on access to care, quality of care, and mortality trends. Although the impetus for the congressional study was the 1986 rate reduction, the report focuses on the 1983 reduction, which was substantially higher and for which more data on utilization and patient outcomes could be collected because of the passage of time.

Developing a Prospective Payment System for Excluded Hospitals

This *Report to Congress* is mandated by section 603(a)(2)(C)(ii) of Public Law 98-21 of the 1983 Amendments to the Social Security Act. It focuses on a wide range of Health Care Financing Administration

research studies conducted over the last 3 years regarding the inclusion of four classes of facilities excluded under the prospective payment system (PPS). The report reviews the research studies for each hospital class—children's psychiatric, rehabilitation, and long-term care—to determine whether the findings support legislative and regulatory recommendations for inclusion of each class of facilities under PPS. In addition, the report addresses several points about the nearly 2,000 facilities receiving exclusion status that need to be considered in research and policy development effort.

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Requests for the following publications should be sent to the Health Care Financing Administration, Bureau of Data Management and Strategy, Division of Information Analysis, Third Floor, Security Office Park Building, 7000 Security Boulevard, Baltimore, Maryland 21207. Telephone requests can be made to (410) 597-3933.

HCFA Statistics, 1991

This reference booklet provides significant summary information about national care expenditures and the Health Care Financing Administration program.

End Stage Renal Disease, 1990

This *Research Report* reflects a wide range of data and analyses regarding the end stage renal disease program. Much of the data emphasize trends and comparisons over time, making the report a standard reference source which illustrate changes in the nature of the Medicare end stage renal disease population and in the patterns of treatment.

Medicare Enrollment, 1986-87

This report contains data on Medicare enrollment and provides information on the characteristics of the aged and disabled populations using services covered by the hospital insurance and supplementary medical insurance programs.

Publications for Sale from the National Technical Information Service (NTIS)

How to Order

Following are the abstracts from final reports describing completed grants and contracts. They may be ordered or further information obtained from: National Technical Information Service, Document Sales, 5285 Port Royal Road, Springfield, Virginia 22161, (703) 487-4650. There is a $3.00 handling charge per order. Prices are current as of this printing but may be subject to change.

Analysis of Medicare Customary Charge Distributions

The goal of this project is to test the feasibility of effectively and efficiently acquiring physician pricing data on customary charges. Data files containing customary, prevailing, and reasonable charge (CPR) pricing and provider information were obtained directly from Medicare Part B carriers. Other phases included: acquiring additional data files on Part B claims experience for the original study States, expanding the study to include pricing and claims data from additional States, the redistributive effects of implementing the Medicare fee schedule in 1992, and acquiring and validating updated carrier CPR pricing files.

Accession No.: PB92-115914
Price: $19.00 paper copy; $9.00 microfiche

Geographic Border Crossing: Implications for Volume Performance Standards

This paper predominately focuses on determining how much substantial geographic variation exists across both States and urban and rural areas in border crossings to seek services.

Accession No.: PB92-128586
Price: $19.00 paper copy; $9.00 microfiche

Hospital Service and Productivity Databook: 1963-90

This is a compilation of the American Hospital Association data covering 25 years of hospital performance with special emphasis on the period from 1984 to 1990 following the implementation of Medicare's prospective payment system. The databook summarizes the changing structure of the industry, including the decline in the number of short-term hospitals and beds and the rapidly expanding scope of services offered. Also shown are the overall trends in expenses, revenues, and selected measures of utilization in the period from 1965 to 1989; the growth in hospital employment, decomposed by hospital ownership and by over 30 occupational categories.

Accession No.: PB92-121037
Price: $19.00 paper copy; $9.00 microfiche

Medical Assistance Facility Certification Criteria

This study provides detailed descriptive information on two proposed alternatives to rural hospitals: the medical assistance facility and the rural primary care hospital programs. The report examines the estimate that no more than 100 to 150 hospitals would ultimately convert if these programs are implemented on a nationwide basis.

Accession No.: PB92-115781
Price: $19.00 paper copy; $9.00 microfiche

A National Program to Improve the Quality of Intensive Care Unit Services—Final Report

The primary objective of this project was to examine organizational and managerial factors asociated with differences in the intensive care unit (ICU) performance. Clinical and physiological data were collected on about 400 consecutive ICU patients in 42 units in 40 hospitals from May 1988 to November 1989. Using the acute physiology and chronic health evaluation (APACHE) III system, data from each patient's clinical record was reviewed for prognostic stratification.

Accession No.: PB92-121474
Price: $35.00 paper copy; $17.00 microfiche

Texas Nursing Home Case-Mix Project

This project reports the development of a prospective payment methodology based on case mix for the Texas Medicaid Nursing Home Program. The objectives were to develop specialized forms and procedures to collect information on the functional abilities, service needs, and resource utilization of Texas nursing home clients. This information was used for developing a case-mix classification system for analyzing different case-mix indexes; for selecting the index which best accounts for variations in the cost of caring for different types of nursing home patients in Texas; and for providing the appropriate incentives to improve quality and access to services.

Accession No.: PB92-115021
Price: $19.00 paper copy; $9.00 microfiche

Patient Classification System: An Evaluation of the State-of-the-Art

The project objective was to evaluate eight mainstream severity of illness systems for use in conjunction with diagnosis-related groups for hospital payment, hospital management, and quality of care. The analysis was based on approximately 15,000 hospital discharges for fiscal year 1984-85 in a nationally representative sample. A second data base analyzed was the 20-percent sample of the 1988-89 Medicare provider analysis and review (MEDPAR) file, which focused on the predictive validity and reliability of the systems as well as their impact on payment at the hospital level.

Accession No.: PB92-123405
Price: $35.00 paper copy; $17.00 microfiche

Case-Mix Outcomes and Resource Use in Nursing Homes

This project studies the variation in outcomes for nursing home residents and the relationship between case-mix adjusters and quality-based-outcome measures. Studied were a population of residents newly admitted to the nursing home as well as several different cross-sectional samples of residents in different States. Insights into the conceptual, methodological, and operational issues associated with designing and implementing a case-mix adjustment system for the assurance of quality care in nursing homes are provided.

Accession No.: PB92-124403
Price: $26.00 paper copy; unavailable on microfiche

A Summary of States' Efforts to Positively Affect the Quality of Medicaid Nursing Home and Community-Based Services for Persons with Mental Retardation and Related Conditions

This project summarizes the types of activities States engage in that had a positive affect on the quality of home and community-based services for persons with mental retardation and related conditions. It briefly describes specific innovative activities within nine States, which are subsumed under five broad topical areas: case management, personnel training, technical assistance, program monitoring, and information management. Also described are the innovative quality enhancement activities in nine selected States based on information provided by key State agency informants.

Accession No.: PB92-124056
Price: $26.00 paper copy; $12.00 microfiche

Health Care Financing Administration Research Report: End Stage Renal Disease, 1989

The report presents statistics concerning trends in end stage renal disease (ESRD) treatment and detailed discussions of selected health issues involving this population. The data base, along with other ESRD program related data, is contained within the ESRD program management and medical information system (PMMIS), as required by Public Law 95-292(c)(1)(A). PMMIS is designed to serve the needs of the Department of Health and Human Services in support of program analysis, policy development, and epidemiological research. Several of the tables in this report emphasize trends and comparisons over time, making this report a standard reference on the Medicare ESRD population and on ESRD treatment patterns.

Accession No.: PB92-128974
Price: $19.00 paper copy; $9.00 microfiche

Final Report for the Evaluation of the Florida Alternative Health Project

This study evaluated the operational performance of ElderCare, an alternative health plan in Miami, Florida, which attempted to divert frail elderly from institutionalization through the provision of

expanded case-managed medical and support services. Service use and costs were compared with that of a sample of Medicaid beneficiaries in the fee-for-service sector who had been similarly assessed as being nursing home eligible.

Accession No.: PB90-256397
Price: $35.00 paper copy; $12.50 microfiche

The Feasibility of a Medicare Microsimulation Model

Discussed in this report is the feasibility of expanding the Urban Institute's TRIM2 microsimulation model to assist the Health Care Financing Administration in analyzing various Medicare policy proposals. TRIM2 is a simulation model developed to evaluate the distributional effects of tax and transfer programs and to estimate the impact of their cost and revenue.

Accession No.: PB90-242330
Price: $26.00 paper copy; $9.00 microfiche

Trends in Inpatient Use of the Elderly and Other Adults for Selected Procedures: 1982-87

Examined are trends in inpatient use of physician services by the elderly and other adults for selected procedures for 1982-87. The data base used was the national hospital discharge survey, an annual survey. Trends in overall hospital use are reviewed as well as changes in the rates of the following types of general procedures: diagnostic and therapeutic operating room procedures and diagnostic and therapeutic non-operating room procedures.

Accession No.: PB90-225848
Price: $17.00 paper copy; $9.00 microfiche

Geographic Variation in Anesthesiologists' Fees

This report examines anesthesiologists' billing practices in 1986 for nine high-volume, high-dollar Medicare procedures. The data base used is the 1986 Part B Medicare claims from Alabama, Arizona, Connecticut, Georgia, Kansas, New Jersey, Oklahoma, Oregon, Washington, and Wisconsin. This file formed the basis of the reports analyses on geographic variation in anesthesia charges, assignment rates, and unbundling practices. Also explored is the relationship between anestheia and surgery charges. Descriptive and correlation analyses were used to show the magnitude and strength of the relationship. The extensive technical documentation included 39 tables and 3 exhibits.

Accession No.: PB90-22191
Price: $26.00 paper copy; $9.00 microfiche

Prospective Payment System Evaluation Studies—Medicare's Prospective Payment System and Changes in the Status of Acute-Care Hospitals

This report examines the number of hospitals that changed their acute-care status during the 1980s. Included are hospital openings, closures, mergers, and changes to and from acute-care status. By examining more than closures, this report was broader than other recently published analyses. On the other hand, by focusing only on acute-care hospitals, it was narrower than other reports because it ignored changes among specialty hospitals (except for those changing to or from acute-care status). This focus was appropriate, however, because this study was part of an evaluation of the impact of Medicare's prospective payment system on hospitals.

Accession No.: PB90-227190
Price: $19.00 paper copy, $9.00 microfiche

Prospective Payment System Evaluation Studies—Hospital Market Structure and Prospective Payment System

The relationship of the structure of hospital markets to hospital's average costs and to changes in those costs in the first 3 years of

Medicare's prospective payment system (PPS) was explored in this report. These analyses were part of a larger evaluation of the impact of PPS on the Nation's hospital industry. Discussed were the types of market structures, the elements of market structure both in general and for hospitals, and a review of the literature on hospital markets and outcomes.

Accession No.: PB90-229808
Price: $26.00 paper copy: $9.00 microfiche

Prospective Payment System Evaluation Studies—The Impact of Medicare's Prospective Payment System on Technology Diffusion

This report explored the relationship between the prospective payment system (PPS) and the diffusion of complexity-expanding, support, and outpatient services to see if PPS in its initial phase really discouraged the adoption of new services and technologies. The question of access to services in a limited way was explored by asking: Are rural hospitals adopting complexity-expanding and outpatient services at rates similar to urban hospitals? Are new technologies diffusing to new medical services administration, or just piling up in cities already oversupplied? Included were both descriptive and multivariate research.

Accession No.: PB90-243825
Price: $17.00 paper copy; $9.00 microfiche

Prospective Payment System Evaluation Studies—Readmissions and Transfers: The Effects of Prospective Payment System

This report attempted to measure changes in readmission and transfer rates that might reaonably be attributable to prospective payment system by accounting for many of the other factors that can be expected to influence these rates.

Accession No.: PB90-243924
Price: $19.00 paper copy; $9.00 microfiche

Prospective Payment System Evaluation Studies—Changes in Patient Severity and Hospital Utilization Measured with Medisgrps

This paper estimated what changes have occurred concurrent to the decline in admissions, both in severity itself and in hospital utilization while holding constant severity. Changes between 1982 and 1985 were analyzed in severity at admission and discharge, length of stay, in and post-hospital death rates, and rehospitalization. The years 1982 and 1985 were chosen because they represent time points shortly before and after the implementation of Medicare's prospective payment system.

Accession No.: PB90-243858
Price: $17.00 paper copy; $9.00 microfiche

Prospective Payment System Evaluation Studies—Post-Hospital Care and Prospective Payment System: A Synthesis

Summarized in this paper is up-to-date research on the trends in Medicare post-hospital care services and how the prospective payment system (PPS) altered them. Most available research focused on periods during 1981 to 1986 and was incapable of separating PPS effects from the strong trends in general home health and non-hospital service use that characterized this period. Data also was drawn mainly from large samples of beneficiary claims and statistical work based on data defined on episodes surrounding hospitalization. One study used the area-quarter as the unit of analysis, while others utilized the person-level episode data for tracer conditions that include stroke, hip replacement, and pneumonia cases.

Accession No.: PB90-241811
Price: $17.00 paper copy; $9.00 microfiche

Prospective Payment System Evaluation Studies—Effects of PPS on Per Capita Medicare Utilization: 1981-86

This paper examines the utilization of and payment for medical care received under Part A of Medicare from 1981 to 1986. (Hospice care was excluded from the analysis.) It focuses on changes in the quantities and dimensions of care and on the effects of the prospective payment system (PPS) on the amounts and types of care received. The paper developed a set of altemative estimates of the influence of PPS on the per capita utilization of inpatient and post-hospital care by Medicare enrollees.

Accession No.: PB90-228677
Price: $26.00 paper copy; $9.00 microfiche

Competitive Forces Driving Medicare Utilization

The study analyzes how various factors affected the ownership of different types of supplemental insurance and Medicare beneficiaries' utilization of services. The first issue was examined by looking at whether a person owned any supplemental insurance policy in 1982; whether they owned more than one supplemental policy; and whether they owned an effective policy. The second issue was examined by looking at whether a person had a hospital stay in 1982, the number of days, number of physician visits, and the number of total Medicare charges. Data sources included: a detailed 1982 survey of aged Medicare beneficiaries in California, Florida, New Jersey, Washington, Wisconsin, and Mississippi; copies of private health insurance policies owned, Medicare eligibility and utilization data for the sample, and the area resource file.

Accession No. PB90-243841
Price: $26.00 paper copy; $9.00 microfiche

Durable Medical Equipment Competitive Bidding Demonstration

The report comprises of seven reports that covered the design, implementation, and the evaluation of the competitive bidding demonstration for the durable medical equipment industry under Medicare. The demonstration was cancelled because the Omnibus Budget Reconciliation Act of 1987 prohibited the Health Care Financing Administration from implementing it.

Bidding System Design Report

The report reviews the characteristics of the durable medical equipment (DME) industry, the legislative history of Medicare reimbursement policies for DME, and the subsequent policy problems that led to the Health Care Financing Administration's decision to test competitive bidding as an alternative reimbursement system. Several design options were described and analyzed for their possible effects on the Medicare program costs, beneficiary access to quality service and equipment, and general impact on the DME market.

Accession No.: PB90-254186
Price: $19.00 paper copy; $9.00 microfiche

Market Case Studies

This report presents discussions on case studies conducted by Abt Associates that covered three urban areas representing characteristics that could have influenced the market for business practices and structure of suppliers of durable medical equipment. The information was for use in the design of the demonstration.

Accession No.: PB90-254202
Price: $17.00 paper copy; $9.00 microfiche

Implementation and Administration

This report delineates the responsibilities of Abt Associates, Health Care Financing Administration's Office of Demonstrations, Bureau of Program Operations and Regional Offices, and the Medicare carriers for implementing and administering the demonstration. It described the ongoing rules of each of these parties for the 3-year period planned.

Accession No.: PB90-254194
Price: $17.00 paper copy; $9.00 microfiche

Demonstration Design Report

Described in the report were three critical aspects of this demonstration: the bidding system for implementation, the rules for participating in the bidding competition, and the procedures for selecting the sites where bidding would have been demonstrated.

Accession No.: PB90-254178
Price: $26.00 paper copy; $9.00 microfiche

Evaluation Design Report

Examined in this demonstration's evaluation design report were policy goals the Health Care Financing Administration hoped to achieve through competitive bidding and a description of outcome measures relating to these goals. Sources of evaluation data were identified for each outcome measure, and schedules for obtaining and analyzing data were given.

Accession No.: PB90-254228
Price: $19.00 paper copy; $9.00 microfiche

Summary of Bidding System Design

The report described the features of the bidding system to be used in the demonstration: billing rules, reimbursement rules, and procedures. The report also covered the quality assurance mechanisms incorporated in the system. The report established how durable medical equipment products were grouped for bidding, bid evaluation and selection procedures, and how reimbursement levels will be set for all bidders.

Accession No.: PB90-254210
Price: $17.00 paper copy; $9.00 microfiche

Medical Equipment

The study analyzes Medicare reimbursement for durable medical equipment (DME) prior to the implementation of fee schedules in 1989. Since these fee schedules were based on prior reimbursement policies, the Health Care Financing Administration (HCFA) needed knowledge as to particular carrier reimbursement practices and baseline data that could be used to evaluate whether the fee schedules make HCFA's pricing of DME more competitive. The four components of the study were:

- Survey of selected carriers focusing on carrier application of inherent reasonableness guidelines.
- Examination of HCFA's BMAD files for 1984-86 to determine DME payment levels and assignment rates and variation across carriers.
- Full DME claims files for 10 States were reviewed to analyze geographic variations.
- Full DME claim files were used to examine the relationship between hospitalization and DME.

Accession No.: PB90-256298
Pnce: $26.00 paper copy; $9.00 microfiche

The Determinants of the Use of Assistants at Surgery

This study describes factors that influenced the use of assistants at surgery. The first part identified individual procedures used most often by assistants at surgery, or which procedures received the most Medicare assistant-at-surgery dollars. The second part

of the study examined more general factors that might have influenced the use of assistants at surgery, specifically the place of service, the specialty of the primary surgeon, characteristics of the beneficiary region, and characteristics of the hospitals.

Accession No.: PB90-246646
Price: $19.00 paper copy; $9.00 microfiche

Impact of Alternative Medicare Fee Schedules on Physicians

Examined in this report are the independent effects of the resource-based, relative-value scale and the geographic practice cost differences on Medicare physician reimbursement. Four different types of fee schedules were simulated: two different relative-value scales, one charge-based and the other resource-based; two different kinds of conversion scales; one budget neutral at the reasonable charge locality level, and the other based on the geographic practice cost index. The primary data base for the simulations was the 1986 Part B Medicare Annual Data Procedures Files, a 5-percent sample of all Medicare Part B claims submitted by providers.

Accession No.: PB90-225855
Price: $19.00 paper copy; $9.00 microfiche.

Impact Analysis of the Tax Equity and Fiscal Responsibility Act System for Reimbursement of Prospective Payment System—Excluded Hospitals

This work analyzed the impact of the Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982 on prospective payment system-excluded hospitals using data from Medicare Cost Reports for fiscal years 1986 and 1987. It described the financial incentives under TEFRA compared Medicare payments and actual facility average costs concluding that TEFRA will impose larger loses unless these facilities reduce their rate of cost inflation.

Accession No.: PB90-220179
Price: $19.00 paper copy; $9.00 microfiche

The Health Care Financing System and the Uninsured

This report is of a study resulting from the discovery made by the Presidential AIDS Commission that the uninsured and underinsured in general face the same problems with health care access as do those with human immunodeficiency syndrome (HIV) infection. It examined and analyzed the health care financing system regarding the problems of the uninsured, underinsured, and other persons at risk of incurring catastrophic expenses, and the impact of alternative policy approaches for these problems. Additionally, a wide variety of options to expand and extend insurance coverage to the uninsured were analyzed.

Accession No.: PB90-227133
Price: $43.00 paper copy; $12.50 microfiche

The Prospective Payment System's Impact on Rural Hospitals

The primary objective of this study was to examine the impact of the Medicare prospective payment system (PPS) on the Nation's rural acute-care hospitals. The project consisted of three phases:

- Review of recent literature providing anecdotal and State-specific evidence of the problems facing rural hospitals post-PPS.
- Case studies of the rural hospital environment in nine areas across the country.
- Descriptive and multivariate analysis of cost, utilization, profits, and closures of rural hospitals.

The study identified 156 rural hospitals that closed between 1980 and 1987. The majority

of these (85 percent) were located in counties with other acute-care hospitals.

Accession No.: PB90-174129
Price: $35.00 paper copy; $12.50 microfiche

Study to Evaluate the Use of Mail Service Pharmacies

This report resulted from the Medicare Catastrophic Coverage Act (MCCA) of 1988 mandate "to evaluate the potential to use mail service pharmacies to reduce costs to the Medicare program" (section 202(k)(1)(B). Because of the repeal of MCCA, the report was not presented to Congress. The study was based on data from the literature and from a mail questionnaire and followup visits to a sample of mail service pharmacies.

Accession No.: PB90-172677
Price: $19.00 paper copy; $9.00 microfiche

Toward a Typology of Health Maintenance Organizations Reflecting Financing Incentives to Physicians

The report surveyed 260 health maintenance organizations (HMOs) for calendar year 1988 in order to develop a more adequate way to classify existing typology. The financial incentives HMOs gave their physicians were compared, since these incentives reflect the fundamental differences in the way HMOs are organized and in how they contract with physicians.

Accession No.: PB90-161050
Price: $17.00 paper copy; $9.00 microfiche

Predicting Costs of Hospitalization for Cancer Care

This report is a descriptive analysis of a 20-percent sample of Medicare inpatient discharges from fiscal year 1984 with respect to utilization and expenditures. The researchers developed a purpose of admission typology—containing six categories—in order to group cancer cases for three common types: lung, colon, and breast. The typology was developed such that it relied only on data available in the discharge file. The purpose of admission typology was tested on 2 databases: a 20-percent sample of Medicare discharges from 1985 and a sample of over 700 cases abstracted from medical charts in 5 Boston hospitals.

Accession No.: PB90-205295
Price: $26.00 paper copy; $9.00 microfiche

The Relationship Between Marketing Strategies and Risk Selection in Medicare At-Risk Health Maintenance Organizations

The study related the experience of health risk selection with the marketing activities of a non-random sample of 22 health maintenance organizations (HMOs) in 12 cities, which were soliciting Medicare Tax Equity and Fiscal Responsibility Act enrollments during Summer 1988. In addition to detailed case studies analyzing the specific marketing decisions of each HMO, a mail survey of enrollees and a comparison group of non-enrollees in each market (total number, 10,035) were conducted to assess the functional health status of the respondents and the factors responsible for enrollment decisions.

Accession No.: PB90-205303
Price: $35.00 paper copy; $12.50 microfiche

Demonstrations and Designs of Alternative Reimbursement Methods for Home Health Services

This *Report to Congress* was prepared in response to the Orphan Drug Act (Public Law 97-414), which required a report to Congress concerning demonstration projects' testing of alternative reimbursement systems for home health services paid by Medicare. In this report, the Health Care Financing Administration presents a synthesis of current

knowledge and research on home health care providers and clients, and in particular summarizes the results of demonstration projects and design efforts relating to alternative payments methods.

Accession No.: PB90-172354
Price: $19.00 paper copy; $9.00 microfiche

A Review of Private Sector Payment Methodologies for Hospital Outpatient Services

This study identified the prospective payment systems in the private sector that could be utilized by Medicare. Following numerous contacts with over 180 private insurers, preferred provider organizations, large corporations, third-party administrators, and business coalitions, only 12 private sector organizations had a prospective payment plan in effect. Those systems in place were described by Project HOPE as less elaborate than any of the systems, currently being reviewed within the Health Care Financing Administration and many imitate the Medicare payment system established for ambulatory surgical centers.

Accession No.: PB90-204496
Price: $19.00 paper copy; $9.00 microfiche

A Health Status Measure for Adjusting the Health Maintenance Organization Rates for Medicare Beneficiaries

The purpose of the project was to identify potential health status measures that might be used by the Health Care Financing Administration in conjunction with the adjusted average per capita cost (AAPCC) formula for calculating HMO capitation levels. Beneficiaries in the sample were surveyed by mail or telephone to obtain data for measuring health status in accordance with each of the following scales: a single-item measure of self-rated health, a nine-item summated measure of self-rated health, activities of daily living score, instrumental activities of daily living score, number of self-reported chronic conditions, and presence of certain specific chronic conditions shown to be associated with high health care costs. Findings of the study showed that:

- Demographic factors, including those employed in the current AAPCC formula, are not good predictors of future use and costs.
- Any of the different measures of health status considered in this research, if incorporated into the AAPCC, would improve the prediction of future health services use and costs.
- Indirect measures of health status, including utilization and prior-year payment variables, provide better predictions than do direct measures of health status.

Accession No.: PB90-200262
Price: $26.00 paper copy; $9.00 microfiche

Medicare Hospice Benefit Program Evaluation: Final Summary Report

This report addressed many of the questions raised by the Tax Equity and Fiscal Responsibility Act of 1982 and Deficit Reduction Act of 1984. In fiscal year 1986, the hospice benefit payments of $20 million for about 10,500 Medicare beneficiaries who elected the benefit were less than 1 percent of the total Medicare Part A expenditures. Overall, this study found neither any significant increase in costs nor any significant savings to the Medicare program attributable to the Medicare hospice benefit during the 1984-86 period.

Accession No.: PB90-150053
Price: $35.00 paper copy; $12.50 microfiche

Publications Inquiries

For publication information and requests

Executive Secretariat Staff
Office of Operations Support
Office of Research and Demonstrations
Room 2230, Oak Meadows Building
6340 Security Boulevard
Baltimore, Maryland 21207
Telephone: (410) 966-6584

Statistical inquiries

Inquiries regarding the availability of statistical information other than those pertaining to the specific contents of articles in the *Health Care Financing Review* should be directed to the following components:

For Medicare Statistics

Information Analysis Branch
Decision Support Division
Office of Statistics and Data Management
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